CHAPTER 3 — ENROLLMENT AND APPLICATION

300 Applying for Income Continuation Insurance – New Employee

On an employee's first day of Wisconsin Retirement System (WRS) covered employment, the employer must provide an *Income Continuation Insurance* brochure (ET-2129), which explains the Income Continuation Insurance (ICI) program, along with an *Income Continuation Insurance Application* (ET-2307). The employee **must** complete the employee information area of the application and return it to the employer regardless of whether the employee elects or declines coverage. The employer must complete the relevant employer information on all applications and submit the completed applications to Employee Trust Funds (ETF). (Refer to the application for address information.)

> **Note: The ICI program provides for immediate enrollment eligibility for local elected officials. Local elected officials must enroll within 30 days of taking office or appointment, if coverage is desired.**

Two Enrollment Opportunities

ICI is available to all eligible employees. (See subchapter 200 for further information on eligible employees.) There are two opportunities for an eligible employee to enroll in the ICI Program:

A. Initial Enrollment Period

This enrollment period generally applies to newly hired or rehired employees.

An eligible employee may enroll without evidence of insurability by submitting a completed ICI application to the employer. The employer must receive the completed application within 30 days of the employee's initial eligibility date. (See chart in Subchapter 202.)

B. Evidence of Insurability

The *Evidence of Insurability Application* (ET-2308) is required for employees wishing to enroll in the ICI Program who have missed the initial enrollment period. The *Evidence of Insurability Application* is also required for insured employees wishing to select a shorter elimination period.

An eligible employee who does not apply for ICI within 30 days of becoming eligible may apply for coverage by providing evidence of insurability (EOI). Eligible employees (actively employed and not on leave of absence or layoff) may apply at any time prior to age 70 by completing an *Evidence of Insurability Application* and forwarding it directly to ETF. An application received by ETF more than 30 days after its completion date (i.e., the date the application is signed) will be rejected and the employee will be required to complete a new EOI application.

The *EOI Application* requires that the employee submit medical proof of insurability. Any costs incurred for exams, tests or procedures conducted to prove eligibility are the responsibility of the employee. The plan's third party administrator will review the EOI application.

Employers receive notice of the approval or denial of the EOI application, which should be retained for their records.

Employees have the right to request third party administrator reconsideration if the EOI application is denied. Should the reconsideration also result in denial, a new application will not be considered until a period of one calendar year elapses from the date of the initial application denial.

(See Subchapter 306 for instructions on completing the EOI application.)

301 Employee Completion of ICI Application

The employee **must** complete the following items on the *Income Continuation Insurance Application* (ET-2307) and return the application to the employer no later than 30 days following the initial eligibility date. (See the sample form in subchapter 303.)

A. Complete legal name.
B. Entire permanent address.
C. Social Security number.
D. Birthdate (the employee must be under age 70).
E. Gender.
F. Questions 1-3.
G. Question 4: Complete ONLY the box labeled "Local Government Employees" selecting **ONE** elimination period only.
H. Employee signature. (If missing, the application is invalid and will be returned for signature.)

I. Employee's daytime telephone number.
J. Date employee signed the application.

302 Employer Completion of the ICI Application

The employer **must** complete the following items on the *ICI Application* and forward the application to ETF. (See the sample form in Subchapter 303.)

A. WRS Begin Date. Date employee became eligible for WRS coverage at this employer.

B. Reason for Eligibility and Occurrence Date. (Based on information obtained from a WRS previous service check. Refer to Subchapter 202 for more information about previous service checks.) Check only **ONE** box in this section.

- ❑ **Immediately Eligible On.** Check this box for employees who previously completed six months of service under the WRS, or for local elected officials in the WRS. Indicate the occurrence date.
- ❑ **New employee will have participated in WRS for six calendar months on**. Check this box for new employees and rehired employees who have not previously completed six calendar months of service under the WRS (State and/or Local service) and indicate the occurrence date.
- ❑ **Reinstating coverage upon return from layoff or leave of absence. Leave of absence dates from** ____ **to** ____ . Check this box if an employee who previously had ICI coverage takes a leave of absence, allows coverage to lapse and then returns to eligible employment. Insert the date the leave began and the date the employee returned from leave. Indicate the occurrence date.
- ❑ **Transferred from another State agency on.** Applies only to State employers.
- ❑ **Changed to a longer elimination period (UW Faculty/Academic Staff and local government employees only) on** . Check this box if the employee wants to elect a longer elimination period. An employee may change to a longer elimination period at any time. However, if an employee wants to change to a shorter elimination period, the employee must apply through evidence of insurability.
- ❑ **Eligible through deferred coverage (State employees and UW Faculty/Academic Staff) on.** Applies only to State employers.
- ❑ **Other.** Check this box for a situation that does not fit one of the other categories listed above. For example, if an employee is reinstated through a grievance/settlement, indicate the date the employee returns to work. Refer to Subchapter 207 for more information about settlement agreements and reinstatements.

C. Earnings. Use the employee's WRS earnings as reported in the preceding calendar year or, if applicable, the employee's projected calendar year earnings (see NOTE) then:

- Round the calendar year WRS earnings figure to the next higher thousand;
- Determine the equivalent average monthly earnings;
- Enter the determined monthly earnings in the earnings box; and
- Check the "Monthly" box. ("Biweekly" earning calculations are for state employers only.)

Note: To determine the equivalent average monthly earnings for a newly hired employee or a current employee with an interruption in earnings of three consecutive months or more, project the annual base salary, round to the next higher thousand and divide by 12.

D. Basis of Employment. Check whether the employee's basis of employment is full-time, part-time, seasonal, etc. If part-time, indicate the percentage of full-time employment.

E. Monthly Premium. Premiums are based on earnings entered in the Earnings box and the elimination period selected by the employee. Refer to the Employee Monthly Premium Rates table in Subchapters 401 and 402.

F. **State Agencies Only. Sick Leave Information.** Local employers do not need to complete this section.

F. Employer. Use the same name used for Social Security reporting.

G. Employer Number 69-036. The Employer Identification Number (EIN) is a 12-digit number beginning with 69-036. Indicate the last seven digits of this number (XXXX-XXX).

H. Date Hired with This Employer. The date the employee was hired.

I. Date Received by Employer. The date the employer received the employee's completed application. This date determines when the insurance becomes effective. If this date is missing the coverage effective date will be based on the date ETF receives the application and could cause delay or denial of coverage.

J. Employer Agent Signature. The WRS agent or designated representative must certify that the information on the application is true and correct.

K. Telephone Number. The telephone number of the employer contact person.

L. Effective date of coverage or cancellation. Check the appropriate box. Coverage becomes effective on the first of the month on or following receipt of the application by the employer. For example: If the application is received on the 1st of the month, coverage begins on the 1st. If the application is received on the 2nd through the 31st of the month, coverage begins the first of the following month. If the application is received on or prior to the employee's eligibility date, coverage becomes effective on the eligibility date. (See chart in Subchapter 202.)

303 Sample - *Income Continuation Insurance Application* (ET-2307)

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

INCOME CONTINUATION INSURANCE APPLICATION
Wis. Stat. § 40.61

Return all copies of this application to your payroll section.

TYPE OR PRINT IN INK

EMPLOYEE: COMPLETE AREA BELOW

Employee Name	Last	First	Middle I.	Maiden	Social Security Number
Employee Address	Street				Birthdate (MM/DD/CCYY)
	City	State	Zip	Country and Mail Code (if not USA)	Sex ☐ Male ☐ Female

1. *Check One:*
   - ☐ I wish to cancel my coverage. *Sign below at #5.*
   - ☐ I do not elect coverage. *Sign below at #5.*
   - ☐ I elect coverage and authorize payroll deductions for premiums.
2. *Check One:* ☐ Yes ☐ No I participated under the Wisconsin Retirement System (WRS) prior to being hired by this employer.
3. *Check One:* ☐ Yes ☐ No I withdrew my contributions from WRS.
4. Answer only those questions applicable to your employment status:

STATE EMPLOYEES & UW FACULTY/ACADEMIC STAFF
☐ I was previously employed by the following State agency: _____
From (MM/DD/CCYY) _____
To (MM/DD/CCYY) _____

UW FACULTY/ACADEMIC STAFF
I elect the following calendar day elimination period:
☐ 30-day ☐ 125-day
☐ 90-day ☐ 180-day
I want my coverage to be effective:
☐ Immediate – previously completed 6 mos. WRS service
☐ As soon as possible (upon completion of 6 mos. WRS service)
☐ When State contributes toward premium (defer coverage for 12 months)

LOCAL GOVERNMENT EMPLOYEES
I elect the following calendar day elimination period:
☐ 30-day ☐ 120-day
☐ 60-day ☐ 180-day
☐ 90-day

5. I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I acknowledge that the monthly employee share premium indicated below is being deducted from my earnings to provide ICI coverage.

SIGN HERE

Signature of Employee	Telephone *Area/Number (8:00 – 4:00)*	Date (MM/DD/CCYY)

EMPLOYER: COMPLETE AREA BELOW

WRS Begin Date (MM/DD/CCYY)

Reason for Eligibility (Check Appropriate Box)	Occurrence Date (MM/DD/CCYY)
☐ Immediately eligible on	
☐ New employee will have participated in WRS for six calendar months on	
☐ Reinstating coverage upon return from layoff or leave of absence. Leave of absence dates: from ___/___/___ to ___/___/___	
☐ Transferred from another State agency on	
☐ Changed to a longer elimination period (UW Faculty/Academic Staff and local government employees only) on	
☐ Eligible through deferred coverage (State employees and UW Faculty/Academic Staff) on	
☐ Other (*specify):*	

Earnings	Basis of Employment	Monthly Premium	
		Employee Share	Employer Share
$ ☐ Monthly ☐ Biweekly	☐ Full-Time ☐ Seasonal ☐ Project ☐ LTE ☐ Part-Time _____ % ☐ Academic Year	$	$

STATE AGENCIES ONLY. SICK LEAVE INFORMATION FOR PURPOSES OF DEFERRED COVERAGE OR REINSTATED OR REHIRED EMPLOYEES
Total accumulation of sick leave credits for the preceding 2 calendar years:

Year	Beginning Balance	Sick Leave Earned	Sick Leave Used	Ending Balance

Employer	Employer Number	Date Hired With This Employer (MM/DD/CCYY)	Date Received by Employer (MM/DD/CCYY)
	69-036		

Employer Agent Signature	Telephone *Area/Number*	Effective Date of (MM/DD/CCYY)
		☐ Coverage ___/___/___ ☐ Cancellation ___/___/___

ET-2307 (REV 10/1999)

ETF COPY

304 Distribution of Copies

1. Forward the top copy of the application to ETF, regardless of whether the employee declines, cancels or elects coverage. Each application will be audited, and problem applications will be reviewed with the employer.

2. Retain the Employer Copy for verification purposes.

3. Give the Employee Copy to the employee.

305 Application Due Date and Effective Date of Coverage

Application Type	Salary Rate	Application Due Date	Coverage Effective Date
Initial enrollment – new employee *ICI Application* (ET-2307)	When coverage becomes effective—for new employees, the projected annual base salary is rounded to the next higher thousand and divided by 12 to determine equivalent average monthly earnings.	No later than 30 days after initial eligibility date.	First of the month on or after the date the application is received by the employer and initially eligible.
Evidence of Insurability (ET-2308)	For new employees, the projected annual base salary is rounded to the next higher thousand and divided by 12 to determine equivalent average monthly earnings. OR The earnings reported to WRS for the previous calendar year, rounded to the next higher thousand and divided by 12 to determine equivalent average monthly earnings.	Must be submitted to ETF no later than 30 days after the date the employee signs the *Evidence of Insurability* (ET-2308).	First day of the month following the evidence approval date.
During Leave of Absence	Prepaid premiums continue in the same amount, even if there is an annual premium adjustment period during the Leave of Absence.	To continue coverage the employee must pay premium prior to the end of coverage so there is no lapse in coverage.	May continue coverage up to 36 months.
Union Service Leave of Absence	Prepaid premiums continue in the same amount, even if there is an annual premium adjustment period during the Leave of Absence.	To continue coverage the employee must pay premium prior to the end of coverage so there is no lapse in coverage.	May continue coverage for the duration of the leave.
Return to work after receiving ICI benefits; or after leave of absence, and no lapse in premiums	Premium resumes at the same amount as before. However, if there was an annual premium adjustment period during the employee's absence, then premium is re-determined on the basis of current earnings and rates.	Not Applicable	Not applicable – coverage is continuous.

Application Type	Salary Rate	Application Due Date	Coverage Effective Date
Return to work after leave of absence, and lapse in premiums occurred	Premium resumes at the same amount as before. However, if there was an annual premium adjustment period during the employee's absence, then premium is re-determined on the basis of current earnings and rates.	Within 30 days after return to work	First of the month on or after the date the application is received by the employer.
Permanent change in percentage of appointment (i.e., full-time to part-time and vice versa)	Rate when change is effective	Within 30 days of the change of appointment	Premiums are adjusted the first day of the month on or after the date the change is effective.

306 Instructions for Completing the *Evidence of Insurability Application* (ET-2308)

The *Evidence of Insurability Application* (ET-2308) provides additional opportunities for employees to enroll in the ICI Program if coverage was previously declined, cancelled, lapsed, or denied. It also provides a method by which employees may enroll after missing the initial enrollment period or elect a shorter elimination period.

A. Employer Responsibilities

1. Review the eligibility criteria outlined in Subchapter 200 to determine if the employee is eligible to apply for ICI coverage.

2. Provide the employee with a copy of the *Income Continuation Insurance* brochure (ET-2129) explaining the ICI program.

3. On the *Evidence of Insurability Application*—complete the employee's Social Security number, current employer, employer number 69-036-(XXXX-XXX), occupation and the date eligible for WRS. Give the application to the employee to complete.

4. Instruct the employee to follow the detailed instructions on the first page of the *Evidence of Insurability Application*. Incomplete applications will be returned to the employee and will delay application processing.

B. Employee Responsibilities

1. Follow the directions found on the front of the *Evidence of Insurability Application*. Complete the form as instructed, including all pertinent information, sign and date. Incomplete applications will be returned.

2. Submit the application to ETF no later than 30 days after completion to ensure current medical information. Applications received more than 30 days after the employee signs the application will be rejected. The employee will then be required to complete and submit a new application.

C. Approval/Denial

1. The employee and employer will both be notified of the approval/denial and the effective date of coverage, if applicable, approximately 60 to 90 days from ETF's receipt of the application.

2. For approved applications, the effective date of coverage will be the first of the month following the date the evidence is approved. Premiums are due from that day forward.

3. For denied applications,

   a. Retain the employer's copy of the denial form for future reference. Additional action by the employer is not necessary.

   b. The employee has the right to request reconsideration of the initial denial by submitting a written request to the third party administrator within 90 days of the date of the initial denial.

   c. The employee has the right to request a subsequent review of the reconsideration's denial by requesting a Departmental Determination within 90 days of that denial.

   b. A new application will not be considered until one-year elapses from the date of denial.

307 *Evidence of Insurability Application* (ET-2308)

DEPARTMENT OF EMPLOYE TRUST FUNDS
P.O. Box 7931
Madison, WI 53707-7931

Clearly print or type your name and address below:

First MI Last

EVIDENCE OF INSURABILITY APPLICATION
(Income Continuation Insurance)
Wis. Stat. § 40.61

To keep your application confidential, enclose it in a sealed envelope and submit directly to the Department of Employe Trust Funds.

Social Security Number
Birthdate (Mo/Day/Yr)
Sex ☐ M ☐ F | Height Ft. In. | Weight lbs.
Current Employer or Department
Employer Number **69-036**
Occupation | Date Eligible for WRS (Mo/Day/Yr)

Have you ever applied through ICI Evidence of Insurability before? ☐ Yes ☐ No
Are you applying to shorten your waiting period? ☐ Yes ☐ No

UW FACULTY AND ACADEMIC STAFF
I elect the following waiting period (calendar days):
☐ 30 day ☐ 125 day
☐ 90 day ☐ 180 day

LOCAL GOVERNMENT EMPLOYES ONLY
I elect the following waiting period (calendar days):
☐ 30 day ☐ 90 day ☐ 180 day
☐ 60 day ☐ 120 day

ANSWER EACH OF THE FOLLOWING QUESTIONS CAREFULLY AND COMPLETELY — YES / NO

1 Are you presently in good health and free from physical impairment and pregnancy? If no, explain. ☐ ☐

2 Has any life, health, or accident and sickness insurance application including Income Continuation Insurance been cancelled, rejected, or assigned to a special rate category because of your medical condition? If yes, explain. ☐ ☐

3 Have you, within the last 5 years, made claim for or received disability or retirement payments because of an illness or injury? If yes, give date, amount, company, type of illness or injury, type of insurance, and reason. ☐ ☐

4 During the last 5 years have you been hospitalized, had surgery, or been advised to have surgery? If yes, give date, hospital, doctor and diagnosis. ☐ ☐

5 Have you, within the last 5 years, missed work for more than two weeks because of an illness or injury? If yes, list dates of time off and type of illness or injury. ☐ ☐

6 Have you ever been diagnosed or received treatment by a health care provider or had reason to suspect you have had any of the following conditions:

- ☐ Heart Disease/Attack
- ☐ Chest Pain, Angina, or Shortness of Breath
- ☐ Disorder of Heart Muscles, its Nerves or Vessels
- ☐ Irregular Heart Beat, Murmur or Rheumatic Fever
- ☐ Abnormal Blood Pressure
- ☐ Disorder of Veins or Arteries
- ☐ Diabetes, High or Low Blood Sugar
- ☐ Disorder of Kidneys or Bladder
- ☐ Venereal Disease, Syphilis, Gonorrhea, Genital Warts or Genital Herpes
- ☐ Protein, Blood or Sugar in Urine
- ☐ Night Sweats, Persistent Swollen Glands, or Diarrhea
- ☐ Arthritis, Bursitis or Gout
- ☐ Disorder of Back, Neck or Spine
- ☐ Disorder of Muscles, Bones or Joints
- ☐ Temperomandibular Joint Syndrome (TMJ)
- ☐ Recurrent Abdominal Pain or Hernia
- ☐ Stroke, Epilepsy or Seizure Disorder
- ☐ Migraine or Persistent Headaches
- ☐ Mental or Nervous Disorder
- ☐ Dizziness or Paralysis
- ☐ Asthma, Emphysema, Breathing or Lung Disorder
- ☐ Indigestion, Ulcers or Colitis
- ☐ Cancer of any Type, Past or Present
- ☐ Tumor or Cysts
- ☐ Brain or Nervous System
- ☐ Eyes, Ears, Nose or Throat
- ☐ Skin or Lymph Nodes
- ☐ Prostate, Ovaries or Uterus
- ☐ Stomach, Intestines, Gallbladder or Liver
- ☐ Thyroid or any Gland
- ☐ Treatment to limit use of Alcohol, Other Chemicals or Drugs
- ☐ AIDS or any Disorder of Immune System *
- ☐ Human Immunodeficiency Virus (HIV) *
- ☐ AIDS Related Complex (ARC) *

* You are not required to submit, nor are we seeking a result of an HIV Antibody Test.

If any of the above are checked, give date, nature and period of disability, doctor's name and address and result.

7. Physician who is most familiar with your medical history. Please include physician's full name, address, city, state, zip code.
Name: _____ Address: _____
Date last visited: _____ Reason for visit: _____
Other Physician(s) consulted within the last 5 years: (Add additional names and addresses on a separate sheet of paper, if necessary.)
Name: _____ Address: _____

Upon approval of this application I hereby authorize payroll deductions from my earnings. I hereby authorize any and all physicians, hospitals, clinics, etc. to release to the Wisconsin Department of Employe Trust Funds or the ICI Program Administrator information from my health record. I understand that the specific type of information to be released includes any and **all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testings and results, and/or treatment records**. This release is being made for the purpose of applying for insurance. A copy of this authorization shall be considered as effective and valid as the original and is effective for 90 days from the date signed below.
I understand that Wis. Stat. § 943.395, provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true, correct and complete.

Date (Mo/Day/Yr)	Signature	Telephone No.: Work: ( ) Home: ( )

☐ _____ did not respond to several requests for additional medical information
☐ The medical information received from _____ indicates _____ Reapply: _____
Application: ☐ APPROVED ☐ DENIED Date: By:

For ETF only. Effective date of Coverage (Mo/Day/Yr):

ET-2308 (REV 6/97)

308 Sample Notice of Approval of Coverage Under Evidence of Insurability

«TodaysDate»

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1»
«CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI)
Evidence of Insurability (EOI) Application
Social Security #

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Thank you for completing the Evidence of Insurability Application for enrollment for coverage in the Income Continuation Insurance benefit plan.

On **[DATE]** we reviewed the information supplied on the Evidence of Insurability application and **information provided warrants the approval of enrollment into the Income Continuation Insurance Benefit Plan effective [DATE].** This letter directs your employer to begin payroll deductions for premium and to notify you when deductions begin. The elimination period you selected is **[AMOUNT SELECTED].**

However, omissions or mistakes in the application could cause an otherwise valid claim filed in the future to be denied. Carefully review the answers on your application. If any information shown is not complete and correct or if any requested medical history has not been included, you must write to this office within 10 days, enclosing a copy of your amended Evidence of Insurability application.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

CC: (EMPLOYER)
Dept. of Employee Trust Funds
File

(FOR EMPLOYER USE ONLY)

Earnings	Monthly Premium
❑ Monthly ❑ Biweekly	
$	$

(905)

Sample Notice of Denial of Coverage Under Evidence of Insurability

[Date] **Certified Mail #**

[Employee's Name]
[Address 1]
[City, WI and Zip]

Re: Income Continuation Insurance (ICI)
Evidence of Insurability Application
Social Security #

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Thank you for your application for Income Continuation Insurance coverage through the State of Wisconsin. We have completed our underwriting review of your application for coverage, and have found it necessary to decline coverage for the following reason:

[Reason]

The information used to reach this decision was taken from:

5. EVIDENCE OF INSURABILITY APPLICATION

The reason for this action was based solely on medical underwriting consideration in accordance with standard insurance industry underwriting guidelines.

If you feel that additional information provided by your physician may reverse this determination, you may submit this information directly, along with a written request that authorizes us to reconsider the original decision. Your request should detail the specific reason(s) you feel the decision should be reversed. Please submit this request to:

Broadspire
200 Wheeler Road, 5th Floor
Burlington, MA 01803

Your written request must be received by our office within 90 days from the date of this denial. You will be informed of Broadspire's decision as soon as possible.

If you do not have any additional medical information for consideration, which might reverse our decision, you can reapply for coverage 12 months after the date of this denial.

Once again, thank you for your application and we regret not being able to meet your insurance needs at this time.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds (ETF)

(902)

Sample Notice of Approval of Coverage After Reconsideration

«TodaysDate» **Certified Mail #**

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1»
«CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI)
Evidence of Insurability (EOI) Application
Social Security #

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Thank you for the request for reconsideration of your Income Continuation Insurance (ICI) application under evidence of insurability

On [DATE] we reviewed additional information. **The information provided warrants the reversal of the original denial, and your application for ICI coverage has been approved effective [DATE].** This letter directs your employer to begin payroll deductions for premium and to notify you when deductions begin.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: [Employer]
Department of Employee Trust Funds
File

(904)

Sample Notice of Denial of Coverage After Reconsideration

«TodaysDate» **Certified Mail #**

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI)
Evidence of Insurability (EOI) Application
Social Security #

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Thank you for your request for a reconsideration of your application for Income Continuation Insurance (ICI) through the State of Wisconsin. On [DATE] your application was evaluated. We regret to inform you that the original declination of coverage was upheld.

If you do not agree with this determination you may request a Departmental Determination through the State of Wisconsin Department of Employee Trust Funds (DETF). Please submit your written request for Departmental Determination, along with any additional information that you feel supports a reversal, to the following address:

Department of Employe Trust Funds (DETF)
ATTN: New Employer Unit/Determination
P. O. Box 7931
Madison, WI 53707-7931

Your letter must be received by the DETF within 90 days of the date of this reconsideration denial.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays. You may reapply for ICI coverage 12 months after the date of the original denial of this application.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds

(903)